SERFF Tracking Number:	*HULI-125724944*	*State:*	*Arkansas*
Filing Company:	*Wilton Reassurance Company*	*State Tracking Number:*	*39588*
Company Tracking Number:	*WR-TL-APP101A*		
TOI:	*L04I Individual Life - Term*	*Sub-TOI:*	*L04I.213 Specified Age or Duration - Fixed/Indeterminate Premium - Single Life*
Product Name:	*Term Life to Age 65 with Specified Period*		
Project Name/Number:	*LS 3/5/WR-TL-APP101A*		

Filing at a Glance

Company: Wilton Reassurance Company

Product Name: Term Life to Age 65 with Specified Period	SERFF Tr Num: HULI-125724944	State: ArkansasLH
TOI: L04I Individual Life - Term	SERFF Status: Closed	State Tr Num: 39588
Sub-TOI: L04I.213 Specified Age or Duration - Fixed/Indeterminate Premium - Single Life	Co Tr Num: WR-TL-APP101A	State Status: Approved-Closed
Filing Type: Form	Co Status: Submitted	Reviewer(s): Linda Bird
	Author: Kim Hiar	Disposition Date: 07/14/2008
	Date Submitted: 07/11/2008	Disposition Status: Approved
Implementation Date Requested: 07/15/2008		Implementation Date:

State Filing Description:

General Information

Project Name: LS 3/5	Status of Filing in Domicile: Not Filed
Project Number: WR-TL-APP101A	Date Approved in Domicile:
Requested Filing Mode: File & Use	Domicile Status Comments:
Explanation for Combination/Other:	Market Type: Individual
Submission Type: New Submission	Group Market Size:
Overall Rate Impact:	Group Market Type:
Filing Status Changed: 07/14/2008	
State Status Changed: 07/14/2008	Deemer Date:

Corresponding Filing Tracking Number:

Filing Description:

This application will be used with policy form WR-TL-POL101A-AR that was approved for use in Arkansas on June 3, 2008. It will replace the application form, WR-TL-APP101A-01.

The authorization portion of the application has been revised to comply with the federal HIPAA guidelines. The following sentence has been added to the authorization section: "I understand that any information that is disclosed pursuant to

this authorization may no longer be covered by federal rules governing privacy and confidentiality of health information, but it will not be re-disclosed by the company except as authorized by me or as required by law."

Company and Contact

Filing Contact Information

Kim Hiar, Compliance Manager
1805 Monument Avenue
Richmond, VA 23220

kimberly.hiar@heritageunion.com
(804) 212-2818 [Phone]
(804) 213-0051[FAX]

Filing Company Information

Wilton Reassurance Company
187 Danbury Road
Riverview Building
Wilton, CT 06897
(203) 762-4438 ext. [Phone]

CoCode: 66133
Group Code: 4213
Group Name:
FEIN Number: 41-1760577

State of Domicile: Minnesota
Company Type: L&H
State ID Number:

Filing Fees

Fee Required?	Yes
Fee Amount:	$20.00
Retaliatory?	No
Fee Explanation:	
Per Company:	No

COMPANY	AMOUNT	DATE PROCESSED	TRANSACTION #
Wilton Reassurance Company	$20.00	07/11/2008	21363323

SERFF Tracking Number:	*HULI-125724944*	*State:*	*Arkansas*
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Correspondence Summary

Dispositions

Status	Created By	Created On	Date Submitted
Approved	Linda Bird	07/14/2008	07/14/2008

SERFF Tracking Number:	*HULI-125724944*	*State:*	*Arkansas*
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Disposition

Disposition Date: 07/14/2008
Implementation Date:
Status: Approved
Comment:

Rate data does NOT apply to filing.

SERFF Tracking Number:	*HULI-125724944*	*State:*	*Arkansas*
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Item Type	Item Name	Item Status	Public Access
Supporting Document	Certification/Notice		Yes
Supporting Document	Application		Yes
Supporting Document	Life & Annuity - Acturial Memo		No
Supporting Document	Third Party Authorization Letter		Yes
Form	Term Life Application		Yes

SERFF Tracking Number:	*HULI-125724944*	*State:*	*Arkansas*
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Form Schedule

Lead Form Number: WR-TL-APP101A-02

Review Status	Form Number	Form Type	Form Name	Action	Action Specific Data	Readability	Attachment
	WR-TL-APP101A-02	Application/Enrollment Form	Term Life Application	Initial		52	WR-TL-APP101A-02 Term Application.pdf

SalaryShield®
Life Insurance Application

WILTON REASSURANCE COMPANY
A Minnesota domestic company

Limit of one SalaryShield Enhanced Policy per individual.

You must complete all sections below

Amount of Monthly Coverage (check one)
<☐ $X,XXX> <☐ $X,XXX> <☐ $X,XXX>

Desired Payout Period (check one)
☐ 3 Years ☐ 5 Years

Monthly Benefit Amount <$X,XXX>

First Name _____ MI _____

Last Name _____ SS# ___ - ___ - _____ Date of Birth ___ / ___ / _____
MM / DD / YYYY

Street _____ ☐ Male ☐ Female _____ ft. _____ in. _____ lbs.
Height Weight

City _____ State _____ ZIP _____ Driver's License# _____ State of Issue _____

Primary Phone ( ) _____ Birthplace _____
state or country

Email Address _____ Name of Beneficiary _____

Current Occupation _____ Relationship of Your Beneficiary to You _____

Annual Salary $ _____

Are you a citizen of the United States? ..... ☐ Yes ☐ No
If no, do you have a permanent Visa/green card? ..... ☐ Yes ☐ No

All questions must be completed **Yes No**

1. In the past ten years have you had or been treated for:
   (a) Heart or circulatory disorder, stroke, heart attack, diabetes, cancer, tumor or melanoma? ..... ☐ ☐
   (b) High blood pressure **AND** elevated cholesterol? ..... ☐ ☐
   (c) Emphysema, sleep apnea or other respiratory or lung disorder? ..... ☐ ☐
   (d) Hepatitis or other liver disorder, any kidney disorder, ulcerative colitis, Crohn's or other digestive disorder? ..... ☐ ☐
   (e) Major depression, Alzheimer's, dementia, other nervous or mental disease or disorder? ..... ☐ ☐
   (f) Anemia, leukemia, lymphoma, or other blood disorder, systemic lupus, other connective tissue disorder? ..... ☐ ☐
   (g) Any neurological or muscular disease or disorder? ..... ☐ ☐
2. Within the last 12 months have you been advised to have diagnostic testing or are you contemplating hospitalization or surgery for any condition mentioned above in 1(a)-1(g)? ..... ☐ ☐
3. In the past 7 years have you been treated for or advised to have treatment for drug or alcohol abuse? ..... ☐ ☐
4. Have you ever been treated for or been diagnosed as having AIDS (Acquired Immune Deficiency Syndrome) or HIV (Human Immunodeficiency Virus) infection or have you had test results indicating exposure to the AIDS virus? ..... ☐ ☐
5. Have you used tobacco or any nicotine products within the last 36 months, including cigars? ..... ☐ ☐
6. In the past 3 years, have you been convicted of DUI/DWI, reckless driving, had your license revoked or had 2 or more moving violations? ..... ☐ ☐
7. Have you ever been convicted of a felony? ..... ☐ ☐
8. Are you involved in the operation of an aircraft as a private pilot or involved in any hazardous sport? ..... ☐ ☐
9. Are you currently disabled or have you ever been disabled or ever made a claim or received benefits for disability as a result of sickness or injury for reasons other than maternity? ..... ☐ ☐
10. In the past 3 years, have you been refused life insurance or been offered or issued a modified or rated policy? ..... ☐ ☐
11. Will the coverage applied for replace or change any existing or applied for life insurance or annuity? ..... ☐ ☐

Agreement/Authorization to Obtain and Disclose Information

I have read all of the questions and answers on this application. All responses are true and complete to the best of my knowledge and belief. A copy of this application will be attached to and made a part of the insurance contract. Any insurance issued as a result of this application will not take effect until the full first premium is paid and a policy is delivered to and accepted by the Proposed Insured during his/her lifetime and while such person is in the state of health described in all parts of this application. I acknowledge receiving the "NOTIFICATION" regarding the MIB, Inc. and Fair Credit Reporting Act in the enclosed materials. For use in determining insurability, I authorize [any licensed physician, medical practitioner,] MIB, Inc., any pharmacy related services organization, or consumer reporting agency that has any records or knowledge of the Proposed Insured's medical history to give any such information to Wilton Reassurance Company, its representatives, or reinsurers. This authorization is valid for 24 months from the date signed. A photocopy or facsimile of this authorization will be as valid as the original. I may revoke this authorization for information not then obtained by notifying the Company in writing. Such revocation will not be effective until received by the Company. I understand that any information that is disclosed pursuant to this authorization may no longer be covered by federal rules governing privacy and confidentiality of health information, but it will not be re-disclosed by the company except as authorized by me or as required by law. I understand that I or any authorized representative will receive a copy of this authorization upon request. [I understand that I may request to be interviewed in connection with the preparation of an investigative consumer report. All applications are subject to underwriting approval. I authorize Wilton Reassurance Company to deduct from my bank account or charge my credit card for all premiums due.

[Financial Institution Disclosure: Insurance products and annuities are not a deposit or other obligation of, or guaranteed by a bank, any affiliate of a bank, or savings association, and are not insured by the Federal Deposit Insurance Corporation (FDIC) or any other agency of the United States, a bank, any affiliate of a bank, or savings association. A lump sum benefit payment option is not available for this product in some states.]

Fraud Warning: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison. **CO Residents**: It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines denial of insurance and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado Division of Insurance within the Department of Regulatory Agencies. **DC Residents**: WARNING: It is a crime to provide false or misleading information to an insurer for the purpose of defrauding the insurer or any other person. Penalties include, imprisonment and/or fines. In addition, an insurer may deny insurance benefits, if false information materially related to a claim was provided by the applicant. **KY Residents**: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime. **OH Residents**: Any person who, with intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing false or deceptive statement is guilty of insurance fraud. **PA Residents**: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

Signed at City	State
X	/ /
Signature of Proposed Insured (required—do not print)	Today's Date (required)

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Rate Information

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Supporting Document Schedules

Review Status:

Satisfied -Name: Certification/Notice 07/08/2008

Comments:

Attachment:

Certification of Compliance - WR-TL-APP101-01.pdf

Review Status:

Satisfied -Name: Application 07/08/2008

Comments:

The application has been attached to the Form Schedule tab .

Review Status:

Satisfied -Name: Third Party Authorization Letter 07/11/2008

Comments:

Attachment:

WR Third Party Authorization Letter 26Mar08.pdf

CERTIFICATION OF COMPLIANCE

I certify that in preparation of this filing all statutes, regulations, rules and bulletins have been reviewed, including Rule 19 and Rule 49.

I also certify that all forms contained in this filing comply with the minimum flesch score of 40 as required in Arkansas ACA 23-80-206.

Signature

July 11, 2008

Date

Enrico Treglio

Name

Sr. Vice President

Title

Wilton Re | 187 Danbury Road Riverview Building Wilton, CT 06897

March 26, 2008

NAIC Company Code: 66133

Re: See Attached Forms Listing

Please accept this letter as authorization from Wilton Reassurance Company for Heritage Union Services, LLC. to file any or all policy forms as referenced on the attached form listing on behalf of Wilton Reassurance Company.

Sincerely,

Enrico J. Treglia
Senior Vice President and
Chief Operating Officer
Wilton Reassurance Company

etreglia@wiltonre.com t: 203.762.4438 f: 203.762.4439